

(Your Logo)

## Consent for Medical/Surgical/Emergency Treatment And Child's Medical Information

In presenting my son/daughter \_\_\_\_\_ of \_\_\_\_\_ years  
of age; for diagnosis and treatment, I \_\_\_\_\_ (mother/father/legal guardian), hereby  
voluntarily consent to the rendering of such care, including diagnostic procedures, surgical and medical  
treatment and blood transfusion, by authorized members of the hospital staff or their designees, as may, in  
their professional judgment, be necessary.

I hereby acknowledge that no guarantees have been made to me as to effect of such examinations or  
treatment on child's condition. I have read this form and I certify that I understand its contents.

I hereby give my consent to: \_\_\_\_\_

(name of person/agency) who will be caring for my child \_\_\_\_\_

(name of child) for the \_\_\_\_\_ period to \_\_\_\_\_ arrange for

routine or emergency medical/dental care and treatment necessary to preserve the health of my child.

I acknowledge that I am responsible for all reasonable charges in connection with care and treatment  
rendered during this period.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

**Brought to you by:  
Southern Region EMS Council**

I acknowledge that I am responsible for all reasonable charges in connection with care and treatment rendered during this period.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Child's Name: \_\_\_\_\_ Family Physician: \_\_\_\_\_

Address: \_\_\_\_\_ Pediatrician: \_\_\_\_\_

\_\_\_\_\_  
Surgeon: \_\_\_\_\_

Telephone: \_\_\_\_\_ Orthopedist: \_\_\_\_\_

Name of Insurance Carrier: \_\_\_\_\_ Child's Allergies: \_\_\_\_\_

\_\_\_\_\_

Group # \_\_\_\_\_ Date of last tetanus booster: \_\_\_\_\_

Agreement # \_\_\_\_\_ Medicines child is taking: \_\_\_\_\_

\_\_\_\_\_

IN CASE OF EMERGENCY I CAN BE REACHED AT:

\_\_\_\_\_

\_\_\_\_\_